STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner
v **File No. 88391-001**

Physicians Health Plan of Mid-Michigan
Respondent
_____/

Issued and entered
This 12th day of May 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 10, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* On March 17, 2008, the Commissioner accepted the request.

The issue in this external review can be decided by a contractual analysis. The contract here is the certificate of coverage (the certificate) issued by Physicians Health Plan of Mid-Michigan (PHPMM). The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner is a member of PHPMM. Her health care benefits are defined in the certificate. The certificate provides for both network and non-network benefits. To obtain network benefits, the care must be provided by an in-network provider. Care from non-network providers may be covered but it generally comes with a higher out-of-pocket cost for the PHP member. The

certificate permits in-network-level benefits for out-of-network services when the services are not available from network providers or for emergency services.

The Petitioner had surgery at XXXXX on September 21, 2007, and a consultation and follow-up care with XXXXX, MD. The XXXXX and Dr. XXXXX are not in PHPMM's network. The Petitioner requested authorization and coverage for the surgery and follow-up care at the network level of benefits. PHPMM denied coverage at the network level but approved coverage at the non-network level, which required the Petitioner to meet a $200.00 deductible and then pay 20% of eligible expenses. The Petitioner appealed but PHPMM maintained its determination.

The Petitioner exhausted PHPMM's internal grievance process and received its final adverse determination dated January 10, 2008.

III
ISSUE

Did PHPMM properly deny coverage for the Petitioner's services at the in-network level?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says she initially went to XXXXX, MD, her primary care physician, with complaints of pain in her right wrist and tingling in her thumb. Dr. XXXXX referred her to XXXXX, DO, a PHPMM network orthopedic surgeon. Dr. XXXXX ordered additional tests, including an MRI and bone scan of the right extremity and wrist, and then a bone scan of the entire body after finding a mass in the right wrist. Dr. XXXXX said (September 7, 2007, letter to Dr. XXXXX):

> I reviewed a copy of the bone scan report. This demonstrated an expansile infiltrative lesion involving the distal ulna with cortical thinning and destruction. They thought that the lesion was aggressive appearing and that this could be a giant cell tumor although other malignant processes such as an ostseosarcoma or chondrosarcoma could not be ruled out. There was a questionable extension beyond the bone. She also had a bone scan evaluation. I reviewed the films of this and it appears that the only asymmetric uptake was associated with her distal ulna.
>
> Given her MRI result and the dictated report I feel that she would be best served by evaluation by a tumor specialist for appropriate surgical margins in

> the event that it is a malignant lesion. I have taken the liberty of referring her to Dr. XXXXX in XXXXX for evaluation.

On September 11, 2007, the Petitioner had a consultation with Dr. XXXXX and he determined she needed an open biopsy of her right distal ulna. On September 21, 2007, Dr. XXXXX performed the biopsy at XXXXX and saw the Petitioner for follow-up visits. PHPMM provided coverage at the out-of-network level, applying the deductible and then paying 80% of eligible expenses. The Petitioner argues that coverage should be at the in-network level because the in-network surgeon, Dr. XXXXX, told her he did not have the expertise to perform the surgery and referred her to Dr. XXXXX. Dr. XXXXX is an orthopedic oncologist who specializes in bone tumors. Dr. XXXXX says he is one of only five fellowship-trained specialists in Michigan with his expertise and that the only one in PHPMM's network is off on maternity leave.

The Petitioner argues that because a network surgeon referred her to Dr. XXXXX and there was no network alternative, the services should be covered at the network level.

Physicians Health Plan's Argument

In its January 10, 2008, final adverse determination, PHPMM said it denied the Petitioner's request "because XXXXX does not participate with Physicians Health Plan (PHPMM) and the services you received were available within the PHPMM network."

PHPMM cites these provisions in the certificate:

> **Section 1: What's Covered – Benefits**
>
> **Accessing Benefits**
> You can choose to receive either Network Benefits or Non-network Benefits. To obtain Network Benefits, Covered Health Services must be provided by a Network Physician or other Network provider in the Physician's office or at a Network facility. For facility services, Network Benefits apply to Covered Health Services that are provided at a Network facility by or under the direction of either a Network or non-Network Physician or other provider. For details about when Network Benefits apply see Section 3: Description of Network and Non-Network Benefits.
>
> * * *
>
> **Eligible Expenses**

Eligible Expenses are the amount we determine that we will pay for Benefits. For a complete definition of Eligible Expenses that describes how we determine payment, see Section 10: Glossary of Defined Terms. For network benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

* * *

SECTION 3: Description of Network and Non-Network Benefits

Network Benefits
Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Service which are:

- Provided by or under the direction of a network Physician in a Network Physician's office or at a network facility.

- Emergency Health Services.

- Urgent Care Center services.

* * *

Health Services from Non-Network Providers Paid as Network Benefits
If we determine that specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us, and we will work with you and your Network Physician to coordinate care through a non-Network provider. You are responsible for verifying that we have approved the request. If you see a non-Network provider without verifying in advance that we have approved your visit, Network Benefits will not be paid. Non-Network Benefits may be available if the services you receive are Covered Health Services for which Benefits are provided under the Policy.

Non-Network Benefits
Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a non-Network Physician or other non-Network provider.

- Provided at a non-Network facility.

PHPMM says the services the Petitioner needed were available within its network, noting that XXXXX, MD, of the XXXXX, and XXXXX, MD, of the XXXXX, are both network orthopedic oncologists. PHPMM says, "This level of access is appropriate for the volume of services needed from this type of provider." PHPMM believes it meets the requirements of Michigan law regarding sufficient providers.

Based on the language in the certificate, PHPMM believes that the services from Dr. XXXXX and XXXXX were appropriately covered at the non-network level.

Commissioner's Review

The certificate has two levels of benefits and the Petitioner can receive medically necessary and covered services from either network or non-network providers. However, network benefits are paid by PHPMM at a higher level than non-network benefits. Services from a non-network provider may be covered at the network level under certain circumstances, e.g., services for urgent or emergency care, or when PHPMM does not have the needed care available within its network.

It is the Petitioner's contention that the services she received at XXXXX and from Dr. XXXXX were not available within PHPMM's network. However, PHPMM has identified two orthopedic oncologists in its network, and there is nothing in the record from which the Commissioner could conclude that the Petitioner could not or should not have received services from either of those two doctors.

Michigan law requires health maintenance organizations, like PHPMM, to have sufficient numbers of affiliated (network) providers available or otherwise ensure that enrollees can obtain covered benefits at no greater cost to the enrollee than if the benefit were obtained from a network provider. See Section 3530 of the Insurance Code of 1956, MCL 500.3530. But in this case it does not appear that the issue of the sufficiency of network providers is at issue. The Petitioner received a referral to XXXXX and Dr. XXXXX from Dr. XXXXX, a network physician. The Petitioner may have thought that a referral from a network physician meant that any services would be covered at

the network level of benefits. Nevertheless, the certificate is clear that non-network services are paid at a lower level than network benefits. Furthermore, there is no documentation to show that either Dr. XXXXX or the Petitioner contacted PHPMM about finding a network provider before proceeding with services.

The Petitioner also said in her grievance application that "pre-authorization was received by the provider," but PHPMM says that a representative of XXXXX contacted its customer service department and confirmed that the Petitioner would be using non-network benefits for the services she received because XXXXX is not in PHPMM's network. No documentation of pre-authorization was provided.

Since the record here does not establish that PHPMM's network oncology providers were not able to provide medically necessary services for the Petitioner, the Commissioner finds that PHPMM's determination of benefits was appropriate; it is not required to cover any services from Dr. XXXXX and XXXXX at the network level.

V
ORDER

The Commissioner upholds PHPMM's final adverse determination of January 10, 2008. PHPMM is not required to provide network level coverage for the Petitioner's services from out-of-network providers XXXXX and Dr. XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Ken Ross

Commissioner